

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 2 — 1 3

2. STATE:

Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.252(b)

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ 30M
b. FFY 2003 \$ N/A

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Section IV, Page 15

D

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-B, Section IV, Page 15

D

10. SUBJECT OF AMENDMENT: Modify structure for variable cost reimbursement for
certain facilities.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

James K. Haveman, Jr.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

James K. HAVEMAN, Jr.

14. TITLE:

Director

15. DATE SUBMITTED:

6/17/02

16. RETURN TO:

Michigan Department of Community Health
Office of Federal Liaison
Lewis Cass Building - Sixth Floor
320 South Walnut Street
Lansing, MI 48913
ATTN: N. Bishop**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

6/18/02

18. DATE APPROVED:

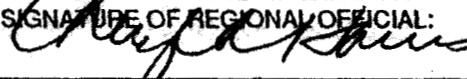
8/23/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

7/1/02 PTH

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED

JUN 18 2002

DMCH/ARA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG-TERM-CARE FACILITIES)

- c. The allowability of costs shall be determined in accordance with Medicare Principles of Reimbursement as modified in Section III above.
3. The rate determination methods using base and support costs to obtain the variable cost component are described below:
 - a. A provider's base cost component is determined as per patient day base costs taken from the provider's fiscal year two years prior to the prospective year times an inflationary adjustor to update costs from the base year to the prospective year. The base cost component will be rebased (recalculated) annually to reflect the more current costs of both the resource needs of patients and the business expenses associated with nursing care. The annual inflationary adjustor will be established by the state legislature for Class I and Class III facilities.
 - 1) For the state fiscal year ending September 30, 2002, the historical inflation adjustor will be five point four percent (5.4%) for general inflation, plus a continuation wage pass-through program of up to \$.50 per hour for all nursing facility employees with the exception of employees constrained by the Owner/Administrator Compensation limits described in Section III.

The prospective inflationary adjustor will be zero percent (0%) general inflationary adjustor. Contained within this prospective adjustor, a wage pass-through program may be requested of up to \$.50 per hour for all nursing facility employees with the exception of employees constrained by the Owner/Administrator Compensation limits described in Section III.
 - 2) For the period July 1, 2002 through September 30, 2002, for all class I and non-public Class III facilities, existing and new rates will be computed or recomputed to add a quality assurance adjustment. This adjustment will be a rate add-on of 10.1 percent of the variable cost component as defined in this plan.

TN No. 02-13

Supersedes

TN No. 01-16

Approval Date: AUG 23 2002

Effective Date: 1-7-1-2002